EXTRACTION

Authorization and Consent for Extraction

DESCRIPTION OF THE PROCEDURE: After anesthetic has numbed the area to be operated on, extraction will be accomplished by either the removal of the tooth/teeth, or by surgical reflection of gum, possible removal of some bone around the tooth/teeth and possible sectioning of tooth roots to facilitate removal of the tooth/teeth. After extraction, tooth socket(s) (hole in jawbone, left by tooth removal) will be inspected, possibly cleansed of debris or infected soft tissue. Finally, the gum and socket or gum tissue may be sutured and measures will be taken to reduce bleeding from the extracted area(s).

ALTERNATIVES TO THE SUGGESTED TREATMENT MAY INCLUDE:

- No treatment, with the expectation of the advancement of my condition resulting in greater risk or complications including but not limited to bone loss, pain, infection, and possible damage to the support of the adjacent teeth.
- Root canal treatment, with the expectation that this may not eliminate infection in the area, or that I may still lose the tooth in the near future.
- Restoration (filling or cap) of this tooth/these teeth with the expectation that it/they may be lost in the near future.

CONSENT

1. It has been explained to me of the need for a dental extraction (the removal of a tooth or several teeth). The reasons for this extraction have been explained to me.
2. I understand the risks of the recommended treatment include, but are not limited to: post surgical infection, post surgical bleeding, swelling, pain, fracture of the tooth/teeth during extraction, retention of part of the root or roots, dislodging of a tooth or part of a tooth into the upper jaw sinus, facial discolouration, transient but on occasion permanent numbness of the lip, tongue, teeth, chin or gum, jaw joint injuries or associated muscle spasms, transient or on occasion permanent increased tooth looseness, tooth sensitivity to hot or cold, sweet or acidic foods, shrinkage of the gum upon healing (which could result in elongation of and/or greater spaces between the teeth). Risks related to the anesthetic might include but are not limited to, allergic reactions, accidental swallowing of foreign matter, facial swelling, bruising, pain or soreness, or discoloration at the injection site.
3. No guarantee, warranty or assurance has been given to me that the proposed surgery will be completely successful in eradicating all pre-existing symptoms or conditions. It is anticipated that the surgery will provide benefit in the reducing the cause of this condition and produce healing which will enhance the possibility of longer retention of my teeth by reducing the problems associated with this tooth/these teeth. Due to individual patient differences, however one cannot predict the absolute certainty of success. Therefore there exists the risk of failure, relapse, selective retreatment or worsening of my present condition, including the loss of certain teeth with advanced involvement despite the best of care.
4. I understand that during surgery, unforeseen conditions could be discovered which would call for a modification or change from the anticipated surgical plan. These may include, but are not

limited to, extraction of hopeless teeth to enhance healing of adjacent teeth, the removal of a hopeless root or a multi-rooted tooth so as to preserve the tooth, or termination of the procedure prior to completion of all the procedures originally scheduled. I, therefore consent to the performance of such additional or alternative procedures as may be deemed necessary in the best judgment of the doctor.

5. I understand that excessive smoking and/or alcohol intake may affect gum healing and may limit the successful outcome of the surgery. I agree to follow the instructions related to the daily care of my mouth and to the use of prescribed medications. I agree to report for appointments as needed following my surgery, so that healing may be monitored and the doctor can evaluate the success of the surgery.
6. I consent to photography, video recording and x-rays of my oral structures as related to these procedures and for their educational use in lectures or publications, provided my identity is not revealed.
7. I CERTIFY THAT I HAVE READ FULLY AND HAVE HAD ALL MY QUESTIONS ANSWERED SATISFACTORILY SO THAT I UNDERSTAND THE ABOVE CONSENT TO TREATMENT BEFORE HEREBY SIGNING.